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MEDICAID MEMO

TO: All Medical Doctors, Nurse Practitioners, Nurse Midwives, Hospitals, Health Departments, Rural Health Clinics, Federally Qualified Health Centers, Laboratories, Pharmacies, and Outpatient Clinics, and Managed Care Organizations (MCOs) Participating in the Virginia Medical Assistance Program

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 12/11/2006

SUBJECT: Family Planning Services Program: Clarification of Eligibility, Covered Services and Billing Requirements

The purpose of this memorandum is to inform providers of clarifications the Department of Medical Assistance Services (DMAS) has received from the Centers for Medicare and Medicaid Services (CMS) regarding eligibility, covered services, and billing requirements for the Family Planning Services (FPS) Program. The revised list of approved FPS procedure codes, supply codes and diagnosis codes are in Attachment 1 and will be effective for services provided on or after December 1, 2006.

Background

DMAS implemented the FPS Program on October 1, 2002. The program focuses on preventing unintended pregnancies, increasing the time between births, and improving pregnancy outcomes. The FPS Program provides coverage of family planning services for women up to 24 months following the end of a Medicaid covered pregnancy. No other Medicaid services are covered.

Eligibility Criteria

In addition to the above mentioned requirements, a woman must have income less than or equal to 133% of the federal poverty level, and not be enrolled in or eligible for another Medicaid-covered group. A woman who does not meet the alien requirements for full Medicaid coverage and whose labor and delivery was paid as an emergency medical service under Medicaid is not eligible to participate in the FPS Program.

CMS has clarified that a woman who has had a tubal ligation, hysterectomy or who is not willing to accept family planning services is not eligible for the FPS Program. A woman who is enrolled in the FPS Program may have a sterilization procedure such as a tubal ligation, but she is no longer eligible for the program after this type of procedure has been performed.

Covered Services

The following services may be covered as part of the routine and periodic family planning office visit:

- Annual gynecological exams and PAP screening (one per 12 months)
- Sexually transmitted infection (STI) testing (limited to initial family planning encounter)
- Laboratory services for family planning and STI testing;
- Family planning education and counseling;
- Contraceptives, including diaphragms, contraceptive injectables, and contraceptive implants that have been approved by the Food and Drug Administration;
- Over-the-counter contraceptives; and
- Sterilizations, not to include hysterectomies.

Office visits are generally performed annually however may be more frequent depending on the method of contraception (e.g. Depo-Provera injections, either Intramuscular every 11 to 13 weeks, or Subcutaneously every 11 to 14 weeks). Laboratory tests are generally performed or recommended during an initial family planning visit and may be processed by an outside laboratory as needed. Additional screening tests are often performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Subsequent routine/periodic family planning visits generally include a Pap test and other screening laboratory tests depending on the method of contraception and the established protocol.

The following services are NOT covered in the FPS Program:

- performance of, counseling for, or recommendations of abortions;
- infertility treatments;
- performance of a hysterectomy;
- transportation to a family planning service;
- primary care services; and
- any service not related to family planning such as urinary tract infection, colposcopy, etc.

Medical complications resulting from a family planning, contraception or sterilization service which requires a level-of-care more intensive than an office or clinic setting are not reimbursable under this program. Examples of such complications would be a perforated uterus or overwhelming uterine infection due to an Intrauterine Device or severe menstrual bleeding caused by Norplant or Depo injection requiring a Dilation and Curettage.

Reimbursement and Claims Submission

Services provided through the FPS Program are reimbursed on a fee-for-service basis. To ensure payment for services, claims must be submitted using authorized Current Procedural Terminology (CPT) codes, International Classification of Diseases, Ninth Revision, and Clinical Modification (ICD-9-CM) procedure codes or Healthcare Common Procedure Coding System (HCPCS) supply codes accompanied with the appropriate ICD-9-CM diagnosis codes listed in Attachment 1. Please pay close attention to the attached list of approved codes. These have been updated per CMS and are the only codes for which providers will be reimbursed for a recipient enrolled in the FPS Program. Please refer to Chapter V of the *Physician Provider Manual* for instructions on claims submission.

Services provided that are not included on the attached list of approved codes will not be reimbursed by DMAS for individuals in the FPS Program. In addition, services included in this list, but not accompanied with an approved ICD-9-CM diagnosis code (which is included in Attachment 1, Table 6), will not be reimbursed by the FPS Program.

Please be aware that these services may be revised subsequent to CMS review of services. It will be the responsibility of the individual provider to adhere to the Medicaid Memos. Upon CMS review of services, Virginia will modify its listing of covered services accordingly.

Because FPS recipients receive a limited benefits package, it is important to assess each Medicaid participant's eligibility and service limit status prior to providing services. Failure to check eligibility and to understand which codes are billable for these individuals may result in unpaid claims.

Claims for Medications

Pharmacy Point of Sale Transactions

DMAS covers both over-the-counter and prescription contraceptives for a maximum 34-day supply of medication per prescription per patient in accordance with the prescriber's orders and subject to Board of Pharmacy regulations. For prescription orders whose quantity exceeds a 34-day supply, refills may be dispensed in sufficient quantity to fulfill the prescription order within the limits of federal and state laws and regulations. Other medications will not be covered for recipients who are in the FPS program.

Physician Administered Medications

For contraceptive injections or other contraceptives that need more than a maximum of a 34-day supply (such as the contraceptive injectable, Depo-Provera, which needs to be administered every three months), the physician should use the CPT code for these types of contraceptives when submitting the claim on a HCFA/CMS-1500 form so that the drug can be covered by the FPS Program.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

“HELPLINE”

The “HELPLINE” is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The “HELPLINE” numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Attachment 1

**Medicaid Family Planning Services
Virginia Department of Medical Assistance Services (DMAS)
Approved Virginia Family Planning Service Codes
Effective December 1, 2006**

The Current Procedural Terminology (CPT) codes listed below in Tables 1, 2, and 3; the Healthcare Common Procedure Coding System (HCPCS) codes in Table 4; and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes listed in Table 5 are approved services covered by the Family Planning Service Program. These services are only covered under the Virginia Family Planning Services Program when accompanied by one of the ICD-9-CM diagnosis codes identified in Table 6.

Table 1

CPT Evaluation and Management (Office Visit/Inpatient Visit) Codes (Must be used with diagnosis codes listed in Table 6)	
Code	Description
99201	Office or other outpatient visit for new patient (10 minute face-to-face)
99202	Office or other outpatient visit for new patient (20 minute face-to-face)
99203	Office or other outpatient visit for new patient (30 minute face-to-face)
99204	Office or other outpatient visit for new patient (45 minute face-to-face)
99205	Office or other outpatient visit for new patient (60 minute face-to-face)
99211	Office or other outpatient visit for established patient (5 minute face-to-face)
99212	Office or other outpatient visit for established patient (10 minute face-to-face)
99213	Office or other outpatient visit for established patient (15 minute face-to-face)
99214	Office or other outpatient visit for established patient (25 minute face-to-face)
99215	Office or other outpatient visit for established patient (40 minute face-to-face)
99221	Initial hospital care, per day, for E & M of patient (30 minutes)
99222	Initial hospital care, per day, for E & M of patient (50 minutes)
99223	Initial hospital care, per day, for E & M of patient (70 minutes)
99231	Subsequent hospital care, per day, for E & M of patient (15 minutes)
99232	Subsequent hospital care, per day, for E & M of patient (25 minutes)
99233	Subsequent hospital care, per day, for E & M of patient (35 minutes)
99238	Hospital discharge day management; 30 minutes or less
99239	more than 30 minutes
99241	Office consultation for new or established patient (15 minutes face-to-face)
99242	Office consultation for new or established patient (30 minutes face-to-face)

Table 1 (continued)

99243	Office consultation for new or established patient (40 minutes face-to-face)
99244	Office consultation for new or established patient (60 minutes face-to-face)
99245	Office consultation for new or established patient (80 minutes face-to-face)
99251	Initial inpatient consultation for new or established patient (20 minutes)
99252	Initial inpatient consultation for new or established patient (40 minutes)
99253	Initial inpatient consultation for new or established patient (55 minutes)
99254	Initial inpatient consultation for new or established patient (80 minutes)
99255	Initial inpatient consultation for new or established patient (110 minutes)

Table 2

CPT Procedure Codes (Must be used with diagnosis codes listed in Table 6)	
Code	Description
00851	Anesthesia for tubal ligation/transection
11975	Insertion, implantable contraceptive capsules
11976	Removal, implantable contraceptive capsules
11977	Removal with reinsertion, implantable contraceptive capsules
36415	Collection of venous blood by venipuncture
57170	Diaphragm or cervical cap fitting with instructions
58300	Insertion of IUD
58301	Removal of IUD
58600	Ligation or transaction of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58611	Ligation or transaction of fallopian tube(s) when done at the time of intra-abdominal surgery. In context of the family planning service program, only covered if performed after the 60 day postpartum period.
58615	Occlusion of fallopian tube(s) by device, vaginal or suprapubic approach
58670	Laparoscopy, surgical; with fulguration of oviducts
58671	with occlusion of oviducts by device
90772	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular (direct physician supervision)
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory

Table 3

CPT Lab Codes (Must be used with diagnosis codes listed in Table 6)	
Code	Description
81000	Urinalysis by dipstick or tablet reagent; non-automated, with microscopy
81001	automated, with microscopy
81002	non-automated, without microscopy
81003	automated, without microscopy
81025	Urine pregnancy test
84703	Gonadotropin, chorionic (hCG); qualitative
85025	Complete Blood Count
86592	Syphilis test; Qualitative
86593	Syphilis test; Quantitative
86631	Antibody; Chlamydia
86632	Chlamydia, IGM
86689	HTLV or HIV antibody, confirmatory test
86696	Herpes simplex, Type 2
86701	HIV-1
86702	HIV-2
86703	HIV-1 AND HIV-2, Single assay
86781	Treponema pallidum, confirmatory test
87110	Culture, Chlamydia, any source
87210	Smear, primary source with interpretation; wet mount for infectious agents
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia
87273	Herpes simplex virus type 2
87274	Herpes simplex virus type 1
87320	Infectious agent antigen detection by enzyme immunoassay technique; Chlamydia trachomatis
87390	HIV-1
87391	HIV-2
87491	Chlamydia trachomatis, amplified probe technique
87529	Herpes simplex virus, amplified probe technique
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87592	Neisseria gonorrhoeae, quantification
87621	Papillomavirus, human, amplified probe technique
87810	Infectious agent detection by immunoassay with direct optical observation; Chlamydia trachomatis
87850	Infectious agent detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
88141	Cytopathology, cervical or vaginal, requiring interpretation by physician

Table 3 (continued)

CPT Lab Codes continued (Must be used with diagnosis codes listed in Table 6)	
88142	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer prep; manual screening under physician supervision
88143	with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	with manual screening and computer-assisted rescreening under physician supervision
88153	with manual screening and rescreening under physician supervision
88154	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation
88164	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88165	with manual screening and rescreening under physician supervision
88166	with manual screening and computer-assisted rescreening under physician supervision
88167	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88175	with screening by automated system and manual rescreening or review, under physician supervision

Table 4

HCPCS Codes (Must be used with diagnosis codes listed in Table 6)	
HCPCS Code	Description
A4261	Cervical cap for contraceptive use
A4266	Diaphragm for contraceptive use
A4268	Contraceptive supply, condom, female, each
A4269	Contraception supply spermicide (e.g. foam, gel), each
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
J1055	Injection, Medroxyprogesterone Acetate for contraceptive use, 150 mg
J1056	Infection, Medroxyprogesterone Acetate/Estradiol Cypionate, 5 mg / 25 mg
J7300	Intrauterine copper contraceptive
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7303	Contraceptive vaginal ring (Nuvaring Vaginal Ring)
J7304	Contraceptive supply, hormone containing patch, each
J8499	Prescription drug, oral, non chemotherapeutic, NOS
S4981	Insertion of levonorgestrel-releasing intrauterine system
S4989	Contraceptive intrauterine device, (e.g. Progestacert IUD), including implants and supplies
S4993	Contraceptive pills for birth control

Table 5

ICD-9-CM Sterilization Procedure Codes (Must be used with diagnosis codes listed in Table 6)	
ICD-9 Code	Description
66.21	Bilateral endoscopic ligation and crushing of fallopian tubes
66.22	Bilateral endoscopic ligation and division of fallopian tubes
66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes
66.31	Other bilateral ligation and crushing of fallopian tubes
66.32	Other bilateral ligation and division of fallopian tubes
66.39	Other bilateral destruction or occlusion of fallopian tubes

Table 6

ICD-9-CM Diagnosis Codes	
Code	Description
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures
V25.03	Encounter for emergency contraceptive counseling and prescription
V25.09	Other family planning advice
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill
V25.42	Intrauterine contraceptive device
V25.43	Implantable subdermal contraceptive
V25.49	Other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.9	Unspecified contraceptive management